SUBSTANCE USE DISORDER and DISABILITIES

Access to Substance Abuse Treatment for People with Disabilities

> "We know that equality of individual ability has never existed and never will, but we do insist that equal opportunity must be sought."
>
> FDR

BACKGROUND:

The Centers for Disease Control and Prevention (CDC) estimates that 14.5% of the U. S. population has a disability. Of this group, CDC estimates that 20% has a substance abuse disorder (SUD). For Massachusetts, this would mean that 179,400 individuals with disabilities have a substance abuse problem (MA pop x 14.5% x 20%).

Although substantial research exists to document the prevalence of co-existing substance use disroder (or SUD) and mental illness, there is less information on persons with SUD and other cognitive or physical disabilities. Some sources of data illuminate aspects of this issue, however. For example, treatment episode data from all licensed SUD treatment programs in New York indicate that approximately 30% of persons receiving treatment services experience a disability co-existing with SUD. The NY treatment episode data indicate that physical disabilities are more frequently listed than mental illness as the co-existing condition (Moore & Weber, 2000). In spite of the prevalence of physical or cognitive disabilities among consumers already in alcohol and drug addiction treatment services, there are limited citations in the literature that address the ramifications for providing treatment to persons with these disabilities (Sacks, et al., 1997; Addiction Research Canada; SAMHSA, 1999).

Current research estimates indicate that one half million persons per year receive vocational rehabilitation (VR) services in the U.S., and approximately one quarter may have an active SUD when they apply for services (Moore & Li, 1994; Heinemann et al., 2008). Illicit drug use appears to be especially high among persons with disabilities relative to the general population (Gilson et al., 1996). Similarly, persons with disabilities appear to have a higher prevalence of alcoholism diagnoses than persons without disabilities (DuFour, et al., 1989). Research indicates that people with acquired disabilities, particularly those of traumatic origin, tend to experience SUD at a substantially higher level than in the general population; prevalence figures among this group are generally in the range of 25–40% (DiNitto & Webb, 1998; SAMHSA, 1998), although in persons with traumatic brain injury or spinal cord injury, these numbers may be as high as 60% (Heinemann, et al., 1989; Corrigan, et al., 1995).

In spite of the high prevalence of disability among persons receiving SUD treatment, there is substantial anecdotal information to indicate that persons with more severe disabilities are routinely denied access to treatment because of real or perceived barriers to serving these persons in community settings (NAADD, 1999; SAMHSA, 1998). Historically, medical and disability service providers under-diagnose or refer persons with SUD, which limits potential referrals, and it also means that persons with co-existing disabilities and SUD may also have more chronic conditions when they do eventually find their way into a SUD treatment program (Heinemann, et al., 2008). At that same time, community providers of SUD treatment are documented as being reluctant to accept someone into treatment if that person requires additional personal attention or

accommodation. Prescribed seizure control medication, a history of impulse control issues or unusual group behavior, severe sensory deficits, or the need for attendant services have been documented as some of the reasons for denial of treatment services (SAMHSA, 1998). In spite of two major Federal laws (i.e., the Americans with Disabilities Act of 1990 and the 1992 Amendments to the Rehabilitation Act of 1973) SUD providers continue to struggle with providing accessible and appropriate services to persons with disabilities (Moore & Lorber, 2004).

RISK FACTORS:

Though individuals with a disability share risk factors for substance use disorders (SUD) with the general population such as genetic predisposition, family history of substance use, situational and cultural opportunities, the dynamics of each disability can increase the level of risk. Following are examples of risk factors associated with Deaf and Hard of Hearing, Blind and Visual Impairment, Intellectual Disability/Developmental Disability, and Traumatic Brain Injury. The extensive literature on SUD and mental illness precludes the need for elaboration at this time.

Deaf and Hard of Hearing

Many individuals who are deaf or hard of hearing grow up in hearing families and communities. This often contributes to communication barriers within the family and difficulty in peer relations. Absent knowledge and support of the Deaf community, isolation may be a common experience. The availability of culturally appropriate information and skills building on prevention and education regarding substance use are very limited. Also, the relative small size of the Deaf community and the stigma associated with alcohol and drug use can contribute to SUD. Designing culturally appropriate SUD and paying for interpreting costs while in treatment are two significant challenges for serving this community.

Blind and Visually Impaired

Many individuals who are blind or visually impaired face a variety of loss, independence, valued activities, employment, changes in relationships, etc. that increases risk for substance use disorders. Clinical anxiety and depression may accompany loss of vision. High risk behaviors that contribute to the loss of vision may continue. Research suggests that alcohol abuse may be particularly problematic for persons who are blind.

Intellectual Disabilities/Developmental Disabilities

Several critical functions and skills associated with intellectual / developmental disabilities increase the risk for SUD: impaired judgment and decision-making, limited interpersonal skills, susceptibility to persuasion and poor relationship management. Additionally, the contemporary emphasis on self-determination and independence provides greater access and opportunity for alcohol and other substance use. Because of the heavy emphasis on group therapy in SUD treatment, persons with ID tend not to benefit from this approach, as well as pose a challenge to the pace of treatment for the larger group.

Traumatic Brain Injury

Cognitive and judgment impairments, as well as emotional problems and depression are common among persons with Traumatic Brain Injury (TBI). Alcohol and substance use may be part of the pre-TBI experience and seen as an appropriate response to the change in capacity. Other

post-TBI life experiences such as diminution of independence, changes in relationships, loss of employment, increase SUD risk. Research suggests that 10% to 20% of individuals develop problems for the first time after TBI. Moreover, following the TBI the brain becomes more sensitive to alcohol and other substance use, and research has shown that any alcohol use can increase the extent of the brain injury. SUD among persons with TBI further depresses employment among a disability group that has one of the lowest post-injury employment rates.

THE MASSACHUSETTS EXPERIENCE:

Although public officials and disability advocates began collaboration on access to substance abuse services in the mid 1980s and formed a Disability Task Force, it was legal action in the 1990s that spurred BSAS providers to comply with ADA requirements to make all treatment facilities accessible. With additional funding to support compliance, 90% of substance abuse treatment facilities achieved physical accessibility by 1995. The DPH BSAS Disability Task Force was eventually disbanded.

During this active "disability focused" period, BSAS established discreet residential treatment services for Deaf and Hard of Hearing consumers. For a variety of reasons, the services were not sustainable. BSAS and the Commission for the Deaf and Hard of Hearing and DMH have established a D/HH Substance Abuse Task Force. BSAS has purchased audio-visual materials on substance abuse for this population; contracted with a vendor to provide outpatient services, and appointed staff to coordinate services for this population. BSAS also supports conferences, workshops and other training and educational opportunities on services to D/HH.

The utilization of BSAS services is limited. A BSAS report on individuals with "handicaps and disabilities" in recovery homes between July 1, 2006 and June 30, 2007 shows that of 5,039 admissions, people with disabilities were as follows:

Mobility: 48 Vision: 55 Hearing: 25 Self-care: 2 Mental Retardation: 0

This level of participation in recovery homes is particularly problematic, as persons with disabilities are more likely to need sustained support for recovery.

PROJECTION OF INDIVIDUALS WITH DISABILITIES AND SUD

DISABILITY	% POPULATION	NUMBER	%SUD	NUMBER
Deaf/Hard of Hearing	8.6	546,022	10%	5460
Visually Impaired CfB registration*		37,739 *	10%	3773
Intellectual / Developmental Disability	2%	120,000	5 %	6000
Traumatic Brain Injury	2%	120,000	50%	60,000
Total Disability (CDC)	14.5%	870,000	20%	179,400

The intent of this state conference is to provide strategies and mobilization of resources to address barriers to SUD treatment for persons with disabilities. This will be accomplished by focusing on five workgroup areas, each representing challenges to persons with disabilities as well as promising approaches for finding solutions. The five areas are as follows:

SUBSTANCE ABUSE EDUCATION: IDENTIFICATION and REFERRAL
This workgroup focuses on enhancing the understanding and skills of disability-related service providers regarding the etiology and expression of substance use disorder within various disability groups and strategies for effective referrals. Prevalence data and its implication for various disability groups, culturally appropriate outreach strategies, and community education approaches will be examined.

PROGRAM ACCESSIBILITY: ASSESSMENT and TREATMENT TECHNOLOGIES
Though there has been significant progress in achieving physical accessibility, programmatic and attitudinal barriers remain for individuals with disabilities and SUD. The focus of this workgroup is to examine current assessment and treatment tools and procedures for referral to treatment in order to identify what modifications are needed in order to increase referrals of individuals with disabilities to SUD treatment.

AFTERCARE: COMMUNITY SUPPORTS, CULTURE OF RECOVERY
This workgroup focuses on the confluence of the culture of recovery with disability culture and their impact on sustainable recovery. The role of disability providers regarding client recovery, support and relapse prevention will be examined as well as barriers to recovery: aspects of disability culture, such as stigma; regulations and practices regarding eligibility and program design; aftercare treatment planning and coordination; and housing, employment, recreation, mentoring, role modeling, etc.

PROCUREMENT: FUNDING and PROGRAM DESIGN
This workgroup focuses on the constraints and opportunities presented by the procurement process and policies. The application and enforcement of ADA and civil rights laws will be examined as well as needed changes in program design. The role of insurance and waiver coverage will be reviewed. Innovative and best practices from other jurisdictions will be explored.

CASE MANAGEMENT
This workgroup focuses on case management in both the substance abuse and disability fields to identify strategies to enhance their impact on effective intervention and recovery support for individuals with disabilities. Staff recruitment, training, supervision and retention will be examined. Examples of best practices will be explored for their applicability to this effort.